THE

APPLICATION AND CARE

OF

PESSARIES

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It will be admitted by all who have used vaginal pessaries extensively in the treatment of uterine displacements, that in order to get good results, much more skill is required in their application and subsequent care, than would be deemed requisite from a perusal of standard works on gynæcology. With but a limited experience, the physician is soon convinced, 1st, that there are numerous pathological conditions affecting the pelvic organs which preclude the employment of this form of treatment; and that, 2d, there are other conditions of disease which require to be cured before pessaries can be applied to advantage.

Of the former class, we have malignant and non-malignant growths. Of the latter are all cases of inflammation of the vaginal, cervical, uterine or para-uterine tissues. The effect of injuries to the parturient passage must receive careful attention. Curreting has often to be resorted to in order to diminish the tendency to metrostaxis and profuse leucorrhœa. Incising a V-shaped piece from the cervix, or partial amputation, may be necessary to diminish the size of the organ, whilst the surgical repair of a laceration may be necessary to accomplish the same results in other cases. Some diseases of the uterine appendages prevent us from obtaining benefits from a pessary which might otherwise be expected.

In many instances, physicians become discouraged from experience with pessaries, and discard them entirely; but success will crown the efforts of those who bear in mind the fact, that the nearer the pelvic

structures can be brought to the standard of health before a pessary is introduced, the more satisfactory will be its employment in every instance. The question first to claim attention is not what pessary to employ, but the more important question: "Have we a case suitable for a pessary?"

Whilst thus emphasizing the importance of preliminary treatment before the introduction of a permanent support to the uterus, I wish at this time to allude more particularly to the application and subsequent care of the instrument.

An ordinary vaginal pessary may be conveniently divided into an anterior and posterior portion; the middle curve of the instrument separates these two parts from each other. Taken together, they, of course, constitute the length of the pessary. This has to conform to the length of the vagina as measured by placing the patient in Sims's position, after the uterus has been replaced, and marking upon the examining finger, or a staff whose end is guarded by a small wad of cotton, the distance from the point of contact of the cotton wad placed back of the cervix in the posterior vaginal fornix, to the depression on the anterior wall of the vagina back of the symphysis pubis.

We next take the measurements of the upper part of the vagina into which we desire to fit the posterior part of the pessary. With the finger we must judge of the width and height of this portion, and in the same way measure the outer or anterior half of the vagina from the point where the lowest part of the pessary will rest upon the pelvic floor, to the depression on the anterior vaginal wall back of the symphysis. We have now to consider the fact that the pessary can exert an influence upon the position of the fundus in two ways. If the axis of the uterus is not bent by a flexion of the body, it may be retained in position by exerting an influence upon the vaginal walls at their point of attachment with the cervical portion. When the anterior wall is drawn tight by the instrument in front, and the posterior wall stretched in the same way, this portion of the uterus is tethered to firm supports anteriorly and posteriorly. Another influence can be exerted by the pessary coming in direct contact with the fundus in case of flexion, by narrowing the posterior part of the instrument in order that it may reach to a higher point in the pelvis. It is upon this principle that Thomas's retroflexion pessary has been constructed. For retroversion and prolapsus, when the vaginal outlet is in its normal condition, and the lumen of the vagina diminishes in diameter from the cervical portion to the vulva,

Smith's modification of the old Hodge pessary is the best form to use; but there are cases in which, from injuries sustained at parturition, the vaginal outlet is too large to retain such an instrument. We can then employ a pessary with the outer portion quite angular and wide, so that the point of the lateral bars will rest upon the posterior aspect of the rami of the pubes. In some cases, a high and narrow posterior bar will keep a pessary from slipping out of the vagina by direct engagement against the posterior part of the fundus.

When a pessary rotates, after having been worn a few days, it is because the size selected was too small. In some cases, especially in the unmarried, the vulvar outlet will not permit of the introduction of a pessary large enough to be retained in its proper position. It is then necessary to have the patient anæsthetized, and to stretch the vulva and perinæum in order to permit of the passage of the proper instrument.

Whilst cases of forward displacement are not accompanied by formidable pelvic distress, they are often the cause of considerable nervous disturbance and vesical irritation; yet many eminent gynæcologists pay but little attention to these displacements. When it is necessary to rectify the malposition, an operation under anæsthesia may have to be resorted to. Especially is this the case when we have to treat a uterus that has been anteflexed for a long time, so that the cervical portion has been imperfectly nourished, and atrophy with contraction have resulted. The operation consists in the separation of the walls of the cervical canal by means of a powerful cervical dilator. In other cases it is only necessary to straighten the organ two or three times during the inter-menstrual period, and have the patient wear a properly-shaped anteversion pessary in the interim.

In cases of acquired anteflexion the latter treatment will often prove efficient. For the congenital form, the former method, by divulsion of the cervix, will be required. When it is necessary to effect replacement by merely straightening the fundus upon the cervix before adjusting the pessary, Molesworth's adjuster will serve a very good purpose. The fundus should be thrown back and retained in this position by the instrument for a few minutes, until the circulation of blood is re-established in the constricted cervical portion. But I am satisfied that the benefits derived from this replacement are not confined to the improvement in the nutrition of the cervical portion alone, but arise also from a free escape of secretions, which is permitted by the straightening of the canal of the uterus, so that

the cavity becomes more nearly aseptic, and as a result, the uterine mucous membrane becomes more healthy, so that catarrhal congestion and increased uterine weight, as factors of disease, are eliminated. The above remarks apply as well to the treatment of retroflexion as to anteflexion.

After the introduction of a pessary, an examination should be made at the expiration of the first week, or, if there has been considerable tenderness, or there is any doubt about the perfect replacement of the organ, it should be made sooner. No woman should pass from the care of her physician without having been informed of the presence of the instrument, nor without having been instructed how to remove it. Vaginal douches should be frequently administered during the continuous use of pessaries. After the replacement of the uterus and the adjustment of a pessary, a woman should be as careful as she would be after the reduction of a luxation and the adjustment of a splint, until she ascertains that she is suffering no inconvenience from the use of the instrument in the vagina. Under such conditions it may be worn through the first menstrual period, after which it had best be removed and an opportunity afforded for the parts to sustain the uterus in its new but normal position unaided; or the application of the pessary may be supplemented by pledgets of cotton introduced into the vagina, to be removed at the expiration of forty-eight hours. In this way it is best to test the retaining power of the uterine supports until we are sure either of their efficiency or inefficiency.

Pessaries should not be worn continuously, nor can they be dispensed with abruptly.

The benefits to be derived from their use during the early months of pregnancy are even more important than at other times. For by their aid we are enabled to remove much of the discomfort experienced from gastric and other disturbances arising from uterine displacement. The same rules should govern us in their application and subsequent care as apply to their use in other cases. After parturition, when there is a tendency for the return of former uterine deviations which existed previous to impregnation, they are contraindicated until uterine involution is effected and the lochial discharge has ceased. Until then we are obliged to restrict our mechanical treatment to manual replacement alone. But the opportunity to cure the case should be made available. When pessaries can be worn, the results obtained after parturition are even more favorable than at any other time, for this is the best opportunity to cure many forms of uterine disease.